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TRI-STATE VETERINARY MEDICAL GROUP

Practice Owner, Nancy Hallam-Smith VMD
Associates
Lauren Alex DVM Christine Barnhorst DVM April Koich DVM

CLIENT REGISTRATION

Thank you for giving us the opportunity to take care of your pets.

Owner's Name _____

Co-Owner's Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Employer _____

AUTHORIZATION

Method of Payment Cash Credit Card Check

If you pay by check you must provide the following information:

Driver's License Number _____ Soc.Sec.Number ____ - ____ - ____

*I assume complete responsibility for all charges incurred with the care of my animal(s).
I also understand that these charges will be paid at the time of treatment and/or release.
A deposit may be required for a hospitalized case.*

*Veterinarian's schedules are often full. When a patient fails to keep an appointment,
that time cannot be utilized by other patients who are ill and need to see a Veterinarian.*

Therefore, we reserve the right to charge for missed appointments.

The fee is the amount applicable to the type of visit that was scheduled.

To avoid charges, cancellations should be made 24 hours in advance.

We are aware that emergencies do arise so please do not hesitate to call if this should occur.

Signature _____ Date _____

Pets: _____
